



Main Subscriber ID Effective Date

--	--

EMPLOYER GROUP MEDICAL AND MEDICARE COORDINATION OF BENEFITS AND/OR PART D PRESCRIPTION DRUG ENROLLMENT REQUEST FORM

To enroll in Health Net's Coordination of Benefits (COB) and/or Part D Prescription Drug Plan (PDP) please provide the following information:																												
Employer or union name:		Group #:																										
Last name:	First name:	MI:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.																									
Birth date (mm/dd/yyyy):		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home phone #: ()																									
Permanent residence – Street address:		Apt #:	City:	State: ZIP:																								
Mailing address (only if different from above):		Apt #:	City:	State: ZIP:																								
Please provide your Medicare insurance information																												
Please take out your Medicare card to complete this section. <ul style="list-style-type: none"> Please fill in these blanks so they match your red, white and blue Medicare card. - OR - <ul style="list-style-type: none"> Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. You must have Medicare Part A or Part B to join a Medicare prescription drug plan.		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center; padding: 2px;">MEDICARE</td> <td style="text-align: center; padding: 2px;"></td> <td style="text-align: center; padding: 2px;">HEALTH INSURANCE</td> </tr> <tr> <td colspan="3" style="text-align: center; padding: 5px;">SAMPLE ONLY</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Name: _____</td> </tr> <tr> <td colspan="2" style="padding: 5px;">Medicare Claim Number _____</td> <td style="padding: 5px;">Sex _____</td> </tr> <tr> <td colspan="3" style="padding: 5px;">_____ - _____ - _____</td> </tr> <tr> <td colspan="2" style="padding: 5px;">Is Entitled To</td> <td style="padding: 5px;">Effective Date</td> </tr> <tr> <td colspan="2" style="padding: 5px;">HOSPITAL (Part A)</td> <td style="padding: 5px;">_____</td> </tr> <tr> <td colspan="2" style="padding: 5px;">MEDICAL (Part B)</td> <td style="padding: 5px;">_____</td> </tr> </table>			MEDICARE		HEALTH INSURANCE	SAMPLE ONLY			Name: _____			Medicare Claim Number _____		Sex _____	_____ - _____ - _____			Is Entitled To		Effective Date	HOSPITAL (Part A)		_____	MEDICAL (Part B)		_____
MEDICARE		HEALTH INSURANCE																										
SAMPLE ONLY																												
Name: _____																												
Medicare Claim Number _____		Sex _____																										
_____ - _____ - _____																												
Is Entitled To		Effective Date																										
HOSPITAL (Part A)		_____																										
MEDICAL (Part B)		_____																										
Provider selection	Language preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	Participating physician group (PPG): _____ PPG ID#: _____	Primary care physician (PCP) name: _____ PCP ID #: _____ <input type="checkbox"/> Prior patient																									
Please read and answer these important questions. NOTE: Medicare eligible spouse or dependent(s) must fill out separate forms. Please contact your employer group administrator.																												
1. Are you the retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," retirement date (mm/dd/yyyy): _____ If "No," name of retiree: _____		2. Are you covering a spouse or dependents under this employer or union plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," name of spouse: _____ Name of dependents: _____																										
3. Do you or your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No																												
4. Do you receive Medicaid benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide your Medicaid number: _____																												
5. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, Worker's Compensation, VA benefits, or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Health Net? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage: Name of other coverage: _____ ID # for coverage: _____																												
6. Are you a resident in a long-term care facility, such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide the following information: Name of institution: _____ Address and phone number of institution: _____																												
7. Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as standard Medicare drug coverage since you became eligible to join a Medicare drug plan? <input type="checkbox"/> Yes <input type="checkbox"/> No																												
Please check the box below if you would prefer us to send you information in a language other than English or in another format: <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Braille, large print format, others																												
Please contact Health Net Member Services at 1-800-806-8811 (TTY users should dial 1-800-929-9955) if you need information in another format or language other than what is listed above. Our office hours are 8:00 a.m.– 8:00 p.m., seven days a week.																												

The information on this page applies to enrollment in group **medical benefits**.

Group information

Check the desired plan as offered by your employer: Medical plan: (Write the plan number next to the product)			Reason for application:
<input type="checkbox"/> HMO: _____	<input type="checkbox"/> Flex Net (Indemnity): _____	<input type="checkbox"/> Select (POS): _____	<input type="checkbox"/> Retiree
<input type="checkbox"/> HMO Variable Copay: _____	<input type="checkbox"/> PPO: _____	<input type="checkbox"/> Select 3-tier POS: _____	<input type="checkbox"/> Open Enrollment
<input type="checkbox"/> HMO Silver Network: _____	<input type="checkbox"/> HSA PPO: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Loss of prior coverage date: _____
<input type="checkbox"/> Elect Open Access SM : _____	<input type="checkbox"/> Out-of-State PPO (OOS PPO): _____		<input type="checkbox"/> COBRA effective date: _____
<input type="checkbox"/> Elect (POS): _____	<input type="checkbox"/> Salud con Health Net: _____		<input type="checkbox"/> Add dependent qualifying event: _____
<input type="checkbox"/> EPO: _____			<input type="checkbox"/> Qualifying event date: _____

Provider selection

Participating physician group/ PPG #	Health Net primary care physician/PCP #	Physician name (First, Last)	Is this your current M.D.?
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have other health coverage? If "Yes," please complete this section. Please fill out the following information to receive proper credit for PREVIOUS COVERAGE, if immediately prior to becoming eligible for this plan, you were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal laws, your employer for FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

Name		Name and address of other insurance carrier			Prior coverage start date	
					MM/DD/YYYY 	
Prior coverage end date	Reason for ending coverage	Group #/ Policy ID #	Is this your primary coverage?	Does it cover?	Medicare	Over-age dependent type
MM/DD/YY 			<input type="checkbox"/> Yes <input type="checkbox"/> No	Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	<input type="checkbox"/> Disabled

Declination of Coverage (Complete this section if any coverage is to be declined by you.)

Declining medical coverage Reason: Other group coverage Individual coverage Other: _____
 Other group coverage by another group (i.e., spouse's employer)

The available coverages have been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s). **By declining coverage, I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.**

Note: If you decline coverage for yourself or an eligible dependent because of coverage under other health insurance, you may be eligible for special enrollment rights if you or your dependent lose eligibility for that coverage. Also, if you acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you and your dependent may be eligible for special enrollment rights. You must request special enrollment within 30 days of the loss of coverage or acquisition of a new dependent.

Employee signature: _____ Date: _____

(ONLY IF DECLINING COVERAGE: If signed in error, please cross out and initial.)

Please read the reverse side and sign below.

Your signature:	Today's date:
If you are the authorized representative, you must sign above and provide the following information:	
Name:	Relationship to enrollee:
Address:	Phone number:

Office use only

Name of staff member/agent/broker (if assisted in enrollment):		Rep ID:
Plan ID #:		
Group #:	ICEP/IEP:	OEP:
Effective date of coverage:	AEP:	SEP (type):
		Not eligible:

By completing this enrollment application, I agree to the following:

Health Net. A stand-alone prescription drug plan with a Medicare contract. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Health Net PDP of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in Health Net PDP will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15–December 7), unless I qualify for certain special circumstances.

Health Net PDP serves a specific service area. If I move out of the area that Health Net PDP serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Health Net PDP network pharmacies. Once I am a member of Health Net PDP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net PDP when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Health Net PDP, he or she may be paid based on my enrollment in Health Net PDP. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Health Net PDP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Net PDP will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under state law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature:**Today's date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____**Address:** _____**Phone number:** (_____) _____ - _____ **Relationship to enrollee:** _____

RETURN FORM TO:

San Bernardino County
Employee Benefits and Services Division (EBSB)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440